

VISITING STUDENT APPLICATION

University of California, San Francisco
HEALTH REQUIREMENTS FORM (page 1 of 2)

- Please consult with your current health care provider who will assist you in fulfilling these requirements.
- If you have any medical condition that contraindicates vaccination, please have your health care provider submit a letter so indicating.

PLEASE RETURN THIS FORM WITH YOUR APPLICATION Evidence of Immunity (Prior history of disease is NOT VALID as evidence of immunity) Please Enter Dates for the Following:		
Measles (rubeola) Vaccines #1 ____/____/____ #2 ____/____/____ (after 1969) mm dd yy mm dd yy	OR	Positive measles titer ____/____/____ mm dd yy
Rubella (German measles) Vaccine #1 ____/____/____ ____/____/____ mm dd yy mm dd yy	OR	Positive rubella titer ____/____/____ mm dd yy
Varicella (Chicken Pox) Vaccines – (dates only) #1 ____/____/____ #2 ____/____/____ mm dd yy mm dd yy	OR	Positive varicella titer (dates only) ____/____/____ mm dd yy
Hepatitis B Vaccines – (dates only) #1 ____/____/____ #2 ____/____/____ mm dd yy mm dd yy	OR	Positive Hep B surf Ab titer (dates only) ____/____/____ mm dd yy
#3 ____/____/____	OR	Positive Hep B core Ab titer (dates only) ____/____/____ mm dd yy
H1N1 Vaccine #1 ____/____/____ mm dd yy		
Seasonal Flu Vaccine #1 ____/____/____ mm dd yy		

STUDENT: PRINT LAST NAME _____ FIRST NAME _____

SIGNATURE _____ DATE _____

HEALTH PROVIDER: I CERTIFY THE ABOVE IS TRUE:

PRINT LAST NAME _____ FIRST NAME _____

SIGNATURE _____ DATE _____

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Negative TB Screening History (submit A or B and C):

A. If you have had annual TB skin testing that has been negative, please submit documentation of two PPD skin tests not greater than 12 months apart and the most recent test being completed within the 12 months prior to your start date at UCSF.

If you have NOT HAD annual TB skin testing: You must submit documentation of two skin tests administered one week apart with both tests being done within the three months prior to entering UCSF.

TEST 1: mm reading _____ Date: ____/____/____

TEST 2: mm reading _____ Date: ____/____/____

Please Note: TB Skin Test Results are considered positive if > 10mm or > 5 mm if any of the following are present.

- HIV +
 - Hematological malignancies
 - Taking Prednisone in dose > 30mg per day
 - Other immunosuppressant condition
 - Had close contact or a known exposure to TB and have a previous history of a 0 mm PPD skin test
 - Fibrotic chest x-ray findings consistent with old TB
- If your test reading meets the criteria for positive, please use the column on the right:

OR

B. You may submit results that show a negative Quantiferon Gold blood test within 12 months of UCSF start date

Quantiferon Gold - Negative - Positive

Date: ____/____/____

AND

C. TB Symptom Review (Must Be submitted for both negative and positive TB screening history):

In the past year, have you experienced any of the following for greater than three weeks?

- | | |
|-----------------------------|------------|
| Excessive sweating at night | - yes - no |
| Excessive weight loss | - yes - no |
| Coughing up blood | - yes - no |
| Excessive Fatigue | - yes - no |
| Hoarseness | - yes - no |
| Persistent coughing | - yes - no |
| Persistent fever | - yes - no |

Date of Most Recent Positive Symptom(s) ____/____/____

Positive TB Screening History (submit A or B and C and D):

A. Positive TB Skin Test:

mm reading _____ Date: ____/____/____

Please Note: TB Skin Test Results are considered positive if > 10mm or > 5 mm if any of the following are present:

- HIV +
- Hematological malignancies
- Taking Prednisone in dose > 30mg per day
- Other immunosuppressant condition
- Had close contact or a known exposure to TB and a previous history of a 0 mm PPD skin test
- Fibrotic chest x-ray findings consistent with old TB

OR

B. Quantiferon Gold test result:

Positive result Date: ____/____/____

AND

C. TB symptom review (please answer the review questions listed in section C in the column to the left)

AND

D. Chest x-ray report is required for either a + TB skin test, or a + Quantiferon Gold test, or a positive symptom review. If the PPD or Quantiferon Gold **converted to positive within the past 2 years**, and no INH was taken for treatment, **OR** symptom review is positive, please submit report of a negative chest x-ray taken within **6 months** of start date at UCSF.

OR

If PPD or Quantiferon was positive more than 2 years ago and no INH was taken for treatment, and the TB symptom review has always been negative, please submit report of a negative chest x-ray taken within **12 months** of start date at UCSF. If 6-9 months of INH (or full TB therapy for active disease) has been completed and the symptom review has been negative since the treatment, then chest x-ray at the time of conversion is adequate.

Chest x-ray Result _____ Date ____/____/____

Did you take INH therapy? - yes - no

Date started: ____/____/____ Date ended: ____/____/____

Length of INH treatment _____ months

STUDENT: PRINT LAST NAME _____ FIRST NAME _____

SIGNATURE _____ DATE _____

HEALTH PROVIDER: I CERTIFY THE ABOVE IS TRUE:

PRINT LAST NAME _____ FIRST NAME _____

SIGNATURE _____ DATE _____